THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF LABOR AND WORKFORCE DEVELOPMENT
DEPARTMENT OF INDUSTRIAL ACCIDENTS

Office of Education and Vocational Rehabilitation
1 Congress St. Suite 100, Boston Massachusetts 02114
Information Line (800) 323-3249 ext. 280 in Massachusetts
(617) 727-4900 ext. 280 Outside Massachusetts
http://www.mass.gov/dia/oevr

DIA Board #: _____

INDIVIDUAL WRITTEN REHABILITATION PROGRAM

Please Print or Type

Client Name: _____ V.R. Provider: _____

Street Address: _____ Street Address: _____

City, State, Zip: _____ City, State, Zip: _____

_____ _____

Tel. Number: _____ Tel. Number: _____

Date of Birth: _____ V.R. Counselor: _____

Pre-Injury Wage: $_____ Insurer: _____

Vocational Goal _____ Claims Representative: _____

DOT Code: _____ Tel. Number: _____

Date of Injury: _____

FUNCTIONAL LIMITATIONS (with supporting documents i.e. physical evaluation etc.):

_____

_____

LEVEL OF SERVICE - Employment Goal: **(Job Placement, Job Modification, OJT, Training)**

_____

_____

_____

VOCATIONAL SERVICES PLANNED & COST:	**FROM**	**TO**	**ESTIMATED COST**
Vocational Counseling and Guidance	_____	_____	$_____
Job Seeking Skills Training (with Resume prep.)	_____	_____	$_____
Transferable Skills	_____	_____	$_____
Job Modification (former Employer)	_____	_____	$_____
Vocational Training (including formal classes)	_____	_____	$_____
On-the-job Training	_____	_____	$_____
Job Development & Placement	_____	_____	$_____

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VOC. SERVICES PLANNED & COST (CONTINUED):	**FROM**	**TO**	**ESTIMATED COST**
Post-Placement Follow-up	_____	_____	**$**_____
Transportation	_____	_____	**$**_____

Program Completion Date:_____ **Total Est. Cost: $**_____

Program Justification: Submit a comprehensive case analysis of the injured worker, including such things as possible obstacles to rehabilitation, financial and family concerns, level of motivation, personal interests and avocations, and the necessary ingredients for asuccessful placement. Include injury restrictions, new job goal, why goal is appropriate, expected placement, salary and growth, injured worker's responsibilities, and VR provider responsibilities. (Attach extra sheets if needed).

_____

_____

_____

_____

_____

_____

EMPLOYEE'S RESPONSIBILITY: I will cooperate and make a good faith effort with all parties involved in my rehabilitation program. This includes the keeping of all appointments and adherence to reasonable requests. I understand that any aspect of my program can be amended with good reason.

SIGNED _____ **DATE** _____

CERTIFIED VR PROVIDER RESPONSIBILITY: I will be responsible for timely delivery of the above-referenced services and agree to carry out my professional duties in the interest of the employee's rehabilitation. I understand that this plan cannot be implemented without the approval of the Office of Education and Vocational Rehabilitation of the Department of Industrial Accidents. Should timelines or costs change in this program, I will notify the key parties and develop a program amendment.

SIGNED _____ **DATE** _____

EMPLOYER/INSURER RESPONSIBILITY: I agree to pay for all reasonable and necessary VR services, and to monitor the costs and timeliness of services.

SIGNED _____ **DATE** _____

OEVR RESPONSIBILITY: I will monitor the delivery of VR services to insure compliance with regulations and policy, ensure cost-effectiveness and quality of services. I agree to conduct team meetings to resolve any conflicts or issues amongst the key parties with respect to VR in a fair, objective and timely manner

SIGNED _____ **DATE** _____